MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
Communicable Disease and Immunization Division
VIRAL CNS INFECTION CASE INVESTIGATION

(Please check appropriate illness)

___ Paralytic Polio _____ Aseptic Meningitis **Identify if Outbreak Related:** _____

____ Encephalitis or Meningoencephalitis ____ Arbovirus Encephalitis

*Note: If **polio** suspected, call MDCH for further guidance immediately.*

CASE IDENTIFYING INFORMATION

Name:_____ Age or Birth date: _____ Sex: ___ Race:_____

Address:_____ Home phone:_____

(Street) (City) (**County**) Work phone:_____

Occupation:_____ Place of Employment:_____

(If infant or student, list school or day care)

Attending Physician: _____ Address & Phone_____

Patient Hospitalized: **Y or N** Hospital:_____

(Admission date) _____ (Discharge date) _____ (City)_____

Survived: **Yes** or **NO**

DATE OF SYMPTOM ONSET: _____

CLINICAL INFORMATION FROM ATTENDING PHYSICIAN: (Circle all that apply)

Fever ____	Confusion/memory loss	Upper respiratory symptoms
Headache	Sensory abnormalities	Rash
Stiff neck/back	Convulsion/tremor	Herpes sores (within 1 month)
Lethargy/somnolence	Photophobia	Stupor/coma

Muscle weakness/paralysis (what muscles?) _____

Other symptoms: _____

Lumbar puncture/CSF examination: **Y or N**

If **yes**: **CSF white blood count**: _____ **Differential:** _____

Other CSF results: **Glucose** _____ **Protein** _____ **Bacterial antigens**_____

If **NO**, how was diagnosis made:_____

Other relevant clinical information: _____

Virology (if obtained)	**Acute Serum**	**Convalescent serum**	**Feces**	**CSF**
Date Spec. Obtained				
Lab Testing Spec. & Test Type				
Results				

EPIDEMIOLOGY
(Obtain from families)

Within **one month** of the onset of symptoms in the patient : **(please circle the appropriate response)**

1) Does the patient know of anyone else with a similar illness? **Yes No**
2) Was the patient exposed to anyone with a respiratory, gastro-intestinal or rash illness? **Yes No**
3) Did the patient travel outside the country? **Yes No**
4) Was there heavy exposure(s) to biting insects? **Y es No**

For any yes answers to the questions above, provide all relevant details (including names, addresses, phone numbers, places, dates, etc.) In the space below or on a separate page to be attached.

Name	Address	Phone #	Date	Places	Other Comments

Home drinking water: **well** **city** **Other**_____
Home sewage system: **septic tank** **city** **Other**_____